Colorado Medicine

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CONTENTS

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LEADING ARTICLES

GET BUSY.

Your attention is again called to the fact that the Colorado State Medical Society will hold its Thirty-fourth Annual Meeting on October 4, 5 and 6. Your attention is also called to the fact that you are not a member of the State Society unless you are in good standing in your local society; therefore it will be necessary to make sure that your dues have been paid for 1904 in your local society so that your name may be reported to me as being entitled to all the privileges of the State Society this year. This being attended to, I beg to remind you that the success of our next meeting depends entirely on our individual members. This means *you*, and you should immediately *Get Busy! Write Something!* Don't write for the sake of writing, but write of some case or disease that interested you. It will interest others. Please send me the title of your paper on or before September 1, so the preliminary program can be published in the September number of this Journal.

Hoping to receive liberal responses I am your obedient servant,

J. M. BLAINE, Secretary.

BRANCHES FOR THE AMERICAN MEDICAL ASSOCIATION.

This subject was referred to in the account of the meeting of the House of Delegates given last month by Dr. Jayne. But it is worthy of more extended notice here and of careful consideration on the part of the members of the State and County Societies. Formal action approving of the establishment of such branches has been deferred until the meeting of the American Medical Association next year. But it is better to have the proposition carefully considered in our local societies before such action is taken, than to make it the subject of complaint and adverse criticism afterward. The report of the Committee on Organization, which brought the matter before the House of Delegates, may be found in the *Journal of the A. M. A.* for June 11, page 1579; and the final disposition made of the recommendation, in the succeeding number of the *Journal*, page 1640. The following suggestions are made, not to propound a policy that any individual or organization is expected to adopt, but to bring into the discussion certain points that have important bearings on the establishment of such branches.

Multiplication of Meetings—It does not seem wise to increase the number of meetings held at points far removed from his home, which the physician can properly be expected to attend if actively interested in the advances of medical science and the organization of his profession. To increase the number of meetings that entail long journeys is to arrange for a maximum expenditure of money, time and health for a minimum advantage in scientific thought and professional comradeship. To increase by a few days the length of a single absence from home would be a small matter, compared with breaking loose two or three times a year for long journeys. If we are to have this new order of meetings —branches of the A. M. A.—they should either be held at the same times and places as the meetings of the State Societies, or they must be held instead of the meetings of the State Societies, or instead of the meeting of the A. M. A.

This point seems to have been appre-

ciated by the Committee on Organization, for they recommended that such a branch meeting be held at the same time and place as the meeting of one of the constituent State Medical Societies. The Committee points out that "The bulk of the attendance under such a plan would be made up of the members in the State in which the meeting was held, as will be the case under any plan, but the attendance of leading men from other states would always be sufficient to add greatly to the interest of the State meeting for that year, and year after year this advantage would be extended to each State embraced in the branch."

It is quite possible that if such branches are established their meetings will ultimately replace the annual meeting of the A. M. A. Long journeys are always required of those who attend the Association meetings, from some portion of the country. These meetings have grown to such a size that but few cities can adequately accommodate them. Then, too, some sections of the Association have grown too large to offer the most favorable conditions for scientific discussions. These things all point to the possible wisdom in the future of subdividing the Association into a few strong branches that can meet annually; except when in three or five years the whole Association might gather in one of the few cities capable of accommodating it.

The Place of the Branch in the General Scheme of Organization—Members of the A. M. A. and its affiliated local societies are now entirely free to form and enter into medical associations of infinite variety; academies, library associations, special societies, medical clubs, coteries, etc., etc. It is becoming common for such special or local organizations to require affiliation with the A. M. A. as one of their conditions of membership. This is a sort of quasi recognition of the supremacy of that body. Suppose a branch of the A. M. A. meeting each year with one of the State Societies, the bulk of the attendance made up of the members of that State Society and swinging round the circle of its constituent State Societies in six to nine years. Could such a branch have any important place in the present general scheme of professional organization? Would its connection be much more vital than the quasi relation of special and local societies above referred to?

The Constitution and By-laws proposed for such branches have not been published; but the only important organic function, so to speak, suggested for the branch is that it provides for the presidents of the constituent state medical societies the honor of vice presidency of the branch. It seems difficult to assign the branches any really important place in the general scheme of organization without interrupting the relation of the State Medical Societies with the Association, or to some extent disorganizing the latter.

The Assignment of States—Altho they formulated a scheme of state assignment, the Committee on Organization pointed out that it was probable that advantageous changes could be suggested by members with regard to their own sections. It is doubtful whether any one in Colorado would have thought of grouping this State with Texas, Kansas, and Indian Territory. It would be difficult to suggest a grouping that all could fully agree upon as best. But the Rocky Mountain Interstate Medical Association, which will meet in Denver next month seems to have reached a better arrangement as to territory. Possibly if this organization would take the necessary steps of compelling its members to affiliate with the A. M. A., and fixing its meetings to correspond with those of the State Societies, it might become the first branch of the American Medical Association.

What Branches May Do—Even with only a loose vice-presidential connection with the general scheme of organization, the branch might bring the stimulus of outside impulses that would be of considerable value to some of the weaker State medical societies. True, wide awake officers or an energetic program committee can now secure this sort of influence by inviting outsiders of the right kind to attend and participate in the annual meeting. But the branch of the American Medical Association might do this better, and do it for those societies which would not of themselves secure such help, and which stand most in need of it. Branches of the kind referred to might also help to prepare for the kind of branch the annual meeting of which may sometime replace the annual meeting of the American Medical Association. The proposed scheme is purely permissive. It would allow of various experiments which might lead to results of value.

Apparently one thought in the minds of those who have favored the formation of branches was that the A. M. A. ought to provide for all sorts of medical organizations, and that branches might replace the "Interstate" and regional associations. Whether a real and permanent need exists for associations of this class is still doubtful. In the old days they offered an opportunity for scientific sessions not interfered with by organization business, or disputes as to the recognition of individuals or societies. But since the State societies, as well as the National organization, relegates these things to the judicial councils and to the House of Delegates leaving the general sessions free for scientific discussions, this advantage of the outside regional association has largely disappeared.

A noticeable thing in the history of these loose, regional organizations has been that they offered an asylum for those who, because of factional strife, individual enmity, or their own unethical practices, were excluded from the State and County societies, or found their atmosphere uncongenial. It is hard to tell to what extent this asylum function of the regional associations has contributed to their success or permanence. But it is a function that branches of the A. M. A. never could perform. With reorganization it has been definitely and permanently established, that membership in the county society is the first essential for membership in any of the organizations that are built upon it. Factional strife and individual enmity must be excluded from any influence in determining who may become members of the County society; and the personality or practices which cannot be tolerated by a liberally organized County society will not be tolerated by any higher organization. The providing of recognition and place for those who cannot command the respect of their professional neighbors, or who regard themselves as superior to the claims of general professional organization, is something that the American Medical Association will not engage in.

EDWARD JACKSON.

ORIGINAL PAPERS

*ACUTE OTITIS MEDIA AND MASTOIDITIS—RECENT CASES.**

BY WM. C. BANE, M. D., DENVER.

It was my intention to present at this meeting a report of the cases of ear disease with involvement of the mastoid that have come under my care during the past few months, dividing them into three groups, viz.: 1. Acute Otitis Media with Mastoid Symptoms, not requiring operation. 2. Cases of Acute Otitis Media with Mastoiditis requiring operation. 3. Those of a chronic type requiring operation.

*Read before the Medical Society of the City and County of Denver, April 15, 1904.

However, owing to the length of the paper I will omit the third group at this time.

FIRST GROUP.

Case I. Acute Otitis Media; Mastoid Tenderness; Recovery.

On January 31, 1904, I was called by Dr. Leonard Freeman to see Mrs. C. E. G., aged 29, at St. Joseph's Hospital. The patient had undergone an abdominal operation and was progressing favorably when inflammation of the throat and right ear developed. The throat was but slightly inflamed. The right drum membrane was markedly congested and some bullae on the posterior superior quadrant were present. For two days previous to the one on which I was called the temperature was normal, but that evening it went up to 100 2/5° and the following evening was 101½° and the pulse 96. The patient was given aspirin in ten grain doses every four hours. A 4 per cent. solution of eucaine B was instilled in the ear. The blebs were incised. Some tenderness of the mastoid appeared on the third day and an ice poultice was applied. Under local anesthesia the drum membrane was incised. Irrigation of the ear with hot boric solution was done three times daily. On the fourth day of the ear affection the temperature came down to 98 3/5° and remained down. There was a profuse serous discharge from the ear for several days. By the thirteenth day all ear symptoms except dullness of hearing had disappeared and the patient was dismissed from the hospital.

Case II. Acute Otitis Media; Mastoiditis; Recovery Without Mastoid Operation.

On March 21, 1904, I was called to see Mrs. P., aged 27, of Goodland, Kansas. Patient was referred by Dr. F. H. Smith on account of severe pain in the left ear and mastoid. The inflammation had existed for one week. Severe pains radiated from the ear throughout the left side of the head. H. W. R. 50/60, L. 1/60. P. 96. Temp. 97 7/10° at midday. The auricle was some swollen and tender. There was marked swelling and tenderness over the mastoid. The drum membrane being dull and bulging was freely incised under local anesthesia. An ice poultice was ordered to be applied to the mastoid and the canal to be irrigated with a boric solution. Calomel and a saline were administered. A free discharge of thick serum followed the incision of the drum membrane, and gradually diminished until the seventh day, when it ceased and the swelling and tenderness of the mastoid also disappeared. On the eighth day after coming under my care the patient was allowed to go home. Two weeks later she wrote me that the ear seemed to be entirely well.

Remarks: The free drainage of the middle ear by the incision and the use of the ice poultice cut short the otitis media and aborted the mastoiditis.

Case III. Acute Otitis Media; Mastoiditis; Recovery Without Mastoid Operation.

Was called to St. Joseph's Hospital by Dr. George Stemen on the morning of March 13, 1904, to see Miss J. Z., aged 18, on account of inflammation of the right ear. The patient had undergone an operation for appendicitis and was progressing nicely when the ear disease became manifest. For four days there had been more or less pain in the ear, and the temperature was not above 99 1/5°. On the morning of the fifth day of the ear complication the temperature suddenly rose to 104 1/5°. I found the drum membrane bulging and the mastoid very tender from the antrum to the tip. Under a general anesthetic the drum membrane was incised and a free flow of serum occurred. Ice poultice was applied to the mastoid and kept there constantly

for several days. For three days the temperature fluctuated from 101 1/5° to 104 3/5°, and the pulse 108 to 148. Then the temperature dropped to 100° and in the next twenty-four hours to normal. The patient was examined by Drs. Freeman and Craig with Dr. Stemen during the high temperature and they could not account for the high temperature except it be due to the ear complications. Dr. Foster examined the ear with me on the second day of the high temperature and advised to continue local and constitutional measures for another day or two. Patient was given calomel and a saline on the third day of the high temperature. Within a short time after a free movement of the bowels the temperature went down and the patient began to improve. The tenderness of the mastoid subsided and discharge from the ear gradually ceased. I examined the ear yesterday (April 14, 1904). The hearing is normal and the drum membrane nearly normal in appearance.

Case IV. Acute Otitis Media; Mastoiditis; Apparent Recovery; Relapse and Mastoid Operation Performed; Recovery.

J. T. W., age 7 years, was brought to the office April 5, 1904, on account of earache. He had had tonsilitis twice during the previous two months. The right ear had pained him some during the attacks of tonsillitis and again for one week before coming to me. Hearing with watch, right ear 3/60, left ear 60/60. There was tenderness in the ear and mastoid upon pressure. The drum head showed marked bulging. Temperature normal. Under local anesthesia the drum membrane was freely incised, permitting of the escape of a thick serous discharge. Four per cent. eucaine B was ordered for local use, ice poultice to be applied to the mastoid, and pure sodium salicylate to be taken internally. In one week all pain had disappeared and the discharge had ceased. The drum membrane was free from bulging and congestion.*

Case V. Acute Otitis Media of Both Ears; Mastoid Tenderness; Recovery Without Mastoid Operation.

On April 13, 1904, I was requested by Dr. J. N. Hall to see R. W., aged 8 years, on account of pain in and back of the left ear. Patient had inflammation of the throat for two days and at the same time pain in both ears, the left being the more severe and preventing sleep. Examination revealed marked tenderness of the left mastoid with congestion and bulging of the membrana tympani. Pulse 120, temperature 101 6/10, respiration 28. Hearing for watch, R. 8/60, L. 3/60. Under cocaine anesthesia I incised the left drum membrane, allowing of free flow of serum. Ice poultice was ordered for the mastoid. Marked relief followed the incision of the drum membrane. The next day pain was more acute in the right ear and mastoid and the right drum membrane showed some bulging. However, I deferred incising the right drum head until later and then got some discharge of mucous. The hearing improved in both ears soon after the incising of the drum membranes and the ears were emptied of the mucous. An ice poultice was used on both mastoids for two or three days. The patient was given two-grain doses of aspirin every four hours for twenty-four hours, when the temperature became normal. A 4 per cent. solution of eucaine B was instilled in the ears three or four times daily. Within a

*A relapse occurred in the case nine days after he was seemingly well. He was exposed to inclement weather, and soon had a return of pain in the ear and tenderness of the mastoid. Profuse discharge of pus appeared and continued from the ear. The mastoid remained tender, and the afternoon temperature was from 1° to 2° above normal. Operated at St. Joseph's Hospital May 7, 1904. Recovery was rapid.

week the discharge had ceased, and all tenderness of the mastoids had disappeared.

SECOND GROUP.

Case I. Acute Otitis Media a Complication of Typhoid Fever; Mastoiditis; Operation; Recovery.

On November 19, 1903, S. S., aged 19 years, was referred to me by Dr. Hickey on account of mastoiditis. The patient had passed through a prolonged attack of typhoid fever in September, 1903, and during the illness the right ear had become involved. Pain developed in the ear and was followed by a discharge, and later pain developed in the mastoid. At first the pain lasted but a few days, then a discharge appeared. Gradually the pain became more constant and severe, and the discharge quite offensive. Hearing with the watch: right ear, not on contact, left ear 50/60. Pulse 108, temperature 99 5/10°, respiration 21, at 2 p. m. There was slight edema on the mastoid and marked tenderness throughout the bone except the tip. The canal was filled with foul pus, the upper inner end of the canal was depressed. Operation was advised and agreed to. On November 21, 1903, patient entered St. Joseph's Hospital and was operated the same day. The cortex was very hard. The antrum was diseased, containing pus and granulation tissue. The tip was healthy in appearance. Patient left the hospital on the fourth day and the wound was closed on the fifteenth day following the operation. The hearing came up to 7/60 A small perforation still existed in the drum membrane four months after the operation.

Case II. Acute Otitis Media of Both Ears; Double Mastoiditis; Operation on one Mastoid; Recovery.

Fred P., aged 20, a Swede. Came to America eighteen months ago. He was admitted to the County Hospital December 25, 1903. He gave a history of having had an attack of inflammation of both ears a few months before coming to Colorado. Three days ago he began having pain in both ears and mastoids, the pain being the more severe in the left ear and side of the head. Hearing quite dull, requiring the elevated voice to be heard. A profuse thick, greenish-yellow discharge was coming from the left ear. Marked tenderness of the left mastoid. Examination of the discharge revealed streptococci in abundance. Pulse 96, temperature 100°. For the next two days the pulse ran from 80 to 90 and the temperature 99 6/10° to 100°. Then the temperature ran up to 102°. Ten cc. of antistreptococcic serum was administered and within twelve hours the temperature came down to 99 2/5°. At the same time the patient claimed he had less pain. An ice poultice was kept constantly in contact with the left mastoid and the ears were irrigated several times daily with hot boric solution. However, on December 13 (six days after admission to the hospital), as the left mastoid remained tender, it was opened. The cortex was quite firm, yet pus was found in the antrum and tip. The wound was cleansed with 5 per cent. solution formalin and alcohol and lightly packed with plain gauze. After the third day the wound was dressed daily until the thirteenth day following the operation, when the patient was allowed to leave the hospital. The wound was dressed every other day for a week longer, when the wound was closed. The right ear recovered nicely under local treatment of ice poultice, irrigation and nitrate of silver.

Case III. Acute Otitis Media; Mastoiditis; Suppuration of Cervical Glands; Operation; Recovery.

On February 22, 1904, I was called by Dr. Hickey to see E. L., a babe of ten months. The child had had pains in and about the left ear for one

week. There was a slight muco-purulent discharge from the left ear. The drum membrane was moderately congested, but not bulging. The auricle was pushed downward and forward by a swelling above and back of it. There was distinct fluctuation felt at the most prominent point of the swelling. The next morning I opened the abscess and found evidence of disease of the bone. With a sharp bone spoon, (McKernon's) I cut away all the softened bone and cleaned out the antrum. The wound was cleansed with carbolic acid and alcohol and lightly packed with sterile gauze.

Dr. Hickey gave the subsequent attention, though I saw the child with him several times. For the first dressing or two the wound looked healthy, then pus began to form and the cervical glands to swell. Later the glands suppurated and had to be opened. Within the next three weeks the fellow ear began to discharge and the cervical glands adjoining to swell, and they finally broke down. The wounds were carefully dressed by Dr. Hickey and every precaution taken to avoid infection. The discharge was examined and reported negative. Finally the ears yielded to local treatment with nitrate of silver and the wounds from opening the glands healed. There was a history of the child having been circumcised and of the wound doing badly. The babe was what might be termed a "pus generator."

Case IV. Acute Otitis Media; Mastoiditis; Operation; Recovery.

G. G. N., aged 23 years. Came under my care at the College Dispensary March 12, 1904. He had acute inflammation of the right ear that had existed for one week. Rupture of the drum membrane had occurred, which allowed of free discharge and gave him so much relief that he left the city. One week later the pain returned. I then made a free incision in the posterior half of the drum membrane, which permitted of a free discharge of thick pus. During the next three weeks the wound in the membrana tympani was kept open and ear emptied of thick pus almost daily with a Siegle suction speculum. There was no tenderness in the mastoid until April 4, 1904, when the pain in the mastoid and side of the head became very severe, accompanied with marked tenderness of mastoid. Pulse was 96, temperature 100 2/10°. On the following day the patient was sent to the County Hospital. When admitted the pulse was 112, temperature 100 6/10°. Ice poultice to mastoid was ordered. He was given ten grains of aspirin every two hours. The ear was irrigated several times daily with hot boric solution. In twenty-four hours there was marked relief of the mastoid tenderness. Pulse dropped to 56 and temperature to 96 6/10°. The discharge was found to contain streptococci. Considering that the discharge had been profuse for five weeks and contained streptococci it was deemed advisable to open the mastoid to cut short the disease. The aspirin was omitted for twenty-four hours before the operation was done. The bone was quite healthy in appearance until the antrum was entered, where pus and granulation tissue were encountered. The tip of the mastoid was healthy. The bleeding was very profuse from the wound, requiring frequent applications of hot water to check it. The wound was packed firmly with plain gauze. All of the stitches were placed but only the upper ones were tied. On the eighth day after the operation most of the stitches were removed. However, the wound was not closed entirely for over three weeks, owing to discharge from wound and canal. The patient put on flesh rapidly, yet the blood state was manifestly poor.

Case V. Acute Otitis Media; Mastoiditis; Operation; Recovery.

J. W. A., aged 51 years, a piano mover, came under my care March 19, 1904.

He had had inflammation of the left ear for three months, but was not inconvenienced by it until about March 9, 1904, when severe pain developed in the ear and left side of the head. The head pain was most severe at a point near two inches back of and half an inch above the upper attachment of the ear. *No pain or tenderness in the mastoid.* The pain had been so severe in the ear that he had not been able to lie down at night for about ten days. Pulse 60, temperature 99°. Discharge from the ear was free, coming through a 3 mm. perforation in the posterior half of the M. T. The discharge was thick and tinged with blood, and contained streptococci. The pus was drawn with a suction speculum, and the ear irrigated. The temperature dropped to 97 6/10 and remained below normal. For two weeks the patient was fairly comfortable and the discharge was free. There was not a particle of tenderness in the mastoid, yet the tender spot above and two inches back of the ear remained. Considering the duration of the disease, the character of the discharge and the tender spot in the head, I advised an operation.

The patient entered St. Joseph's Hospital April 6, 1904. During the previous twenty-four hours he had suffered a great deal of pain in the ear and side of the head, but none in the mastoid. Over the tender spot the tissues had become swollen. The bone appeared healthy for a depth of near half an inch, when the antrum was exposed and found to contain pus and granulation tissue. The probe passed from the antrum backward through a narrow sinus for near one and one-half inches, when it entered a large cell or pocket three-quarters of an inch in diameter. The cell was filled with thick pus and granulation tissue. The bone covering the passage to the cell was about three-eighths of an inch in thickness, but that covering the cell was less than one-quarter an inch thick. Just anterior and projecting above the floor of the cell was the uncovered lateral sinus. My first impression was that the cell was an extra-dural abscess, but careful inspection of the cavity exposed a thin bony floor. The tip of the mastoid was removed and found to be healthy. The wound was cleansed with alcohol and lightly packed with plain gauze. The wound was dressed on the third, sixth and eighth days. On the eighth day the patient left the hospital. The temperature remained low, being 96°, and the pulse was 60. On the eleventh day part of the sutures were removed. The wound was closed on the twenty-first day following the operation. The perforation in the drum membrane remained open.

Case VI. Acute Otitis Media; Mastoiditis; Recovery.

Was called to see H. H. G., by Dr. Blickensderfer at St. Luke's Hospital, April 11, 1904. He was a man 33 years of age, and a resident of Cripple Creek. He was taken with acute pain in the left ear on February 29, 1904. After three days suffering the membrana tympani ruptured, followed by partial relief of pain for one week. Pain then developed back of the ear, accompanied by swelling of the tissues covering the mastoid. An ice coil was used constantly, yet pain continued in the mastoid for ten days, when the swelling disappeared, and he experienced relief from the severe pain, though he had occasional darting pains from the mastoid forward to the left eye and nostril. A relapse in the swelling and mastoid pain occurred about three weeks after the onset of the disease, lasting three or four days. Then for several days he was comparatively comfortable, except for the occasional darting pains. On April 3 a third attack of pain and swelling of mastoid came on, growing worse all the time, and on April 8 he came to Denver. When he was admitted to the hospital at

6 p. m. his pulse was 80, respiration 24, and temperature 98 8/10°. On the afternoon of the 10th his temperature was 99 6/10°. The discharge from the ear had been profuse most of the time since the rupture of the drum membrane. The discharge was negative. Examination on April 11 revealed considerable swelling of the tissues back of the ear, and marked tenderness, upon pressure, all over the mastoid. At 5 p. m. I operated, making the usual curved incision from the tip to half an inch above the attachment of the ear. The bone was quite healthy over the antrum for a depth of three-eighths of an inch. At the tip the bone was broken down, and from that point pus and granulation tissue were found in abundance up and back for an inch and three-quarters. In the removal of the necrosed bone about an inch of dura was uncovered. From the tip there was a sinus that led into the antrum. All diseased bone was curetted away and a free communication with the middle ear was made through the antrum. During one week which has elapsed since the operation, the patient has been quite comfortable. The tissues around the wound are infiltrated with pyogenic micro-organisms, and yesterday showed a disposition to break down. Fortunately there is no evidence of pus formation within the dura.

Remarks: The history of this case suggests that a free incision of the M. T. made within the first twelve hours after the onset of the pain, might have cut short the attack and prevented mastoid complications. (The patient was in the hospital about a month. A great deal of pus with unhealthy granulation tissue was generated in the wound. They were checked by applications of a 10 per cent. solution of nitrate of silver.)

Of the ears involved there were seven of acute otitis media with mastoiditis that yielded to abortive treatment. One of these relapsed and an operation was done. Seven were operated. In two cases the discharge contained streptococci. The period of closing the mastoid wound varied from three to five weeks. All recovered.

TUBERCULOSIS IN ITS RELATIONS TO PUBLIC HEALTH.

By C. E. Cooper, M. D., Denver.

In introducing the subject of tuberculosis and its relation to the public health before this Society, a clear statement of the object of the State Board of Health is decidedly apropos. It was by their request that the subject was placed on the program for discussion.

As the science of hygiene and sanitation advances, those who practice the art, namely, the State and local Boards of Health, are endowed by each legislature with more power. Every year sees improvements in the public health and every Board of Health is continually increasing its utility and demonstrating, as proven by statistical evidence, that the public health is not a subject of temporary or superficial consideration, but demands the mature and careful thought of those versed in political economy. The policy of preserving the public health, based upon the principle that a sound, healthy individual is an asset to the municipality, state or nation, is rapidly reaching the position of importance that it demands.

Legislators, political economists and those to whom the reins of government are entrusted appreciate that a well individual is as much a source of wealth to the community as an acre of yielding ground; and in order to protect such wealth it should be armed against those things that harm it. The ravages of smallpox produced, in those remaining alive in a community after an epidemic had swept over it, the greatest dread, and by their experience a keen appreciation of its importance. Moses, after his wandering through

Egypt to the promised land, understood the value of health among his people and dreaded disease; and his famous Mosaic law was based upon this knowledge. Today it is more generally understood even by those whose path in life is far removed from its immediate influence. The demand for better health laws, cleaner towns and cities, purer food and better sanitary conditions is becoming vastly greater with the closing of each decade; and this demand of the public not only includes a betterment of conditions under which health survives, but especially protection against disease and noxious affections which exist in the individual and are propagated by him through association, carelessness or ignorance.

Appreciating as it does the complexity of the subject,—the seeming conflict between the rights of the public and those of the consumptive, the sociologic condition of the people, the attitude of the medical profession, the dread on the part of many that any measures emanating from public health officials will give rise to a strong anti-consumptive feeling, possibly a persecution,—the State Board of Health, before adopting any regulations or framing any rules for the consumptive, desires the opinion of the medical profession of the state, reserving, however, its independence, nor wishing to be construed as binding itself to act in accordance with the preponderance of opinion as elicited in the discussion which will follow.

It has not been many years since there existed in the medical profession a diversity of opinion as to whether tuberculosis ever originated in Colorado. Today I believe the question has been definitely settled in the affirmative and few, if any, of the profession disagree with this finding. The records of the Denver Bureau of Health show the following mortality from tuberculosis:

Years.	1893	1894	1895	1896	1897	1898
Total deaths from tuberculosis	435	377	428	368	489	501
No. specified as contracted in Colorado	49	51	64	66	88	99
Percentage contracted in Colorado	11.26	13.52	14.95	17.93	17.99	19.77

You will note not only that tuberculosis does originate within our borders, but that there is a gradual annual increase in the percentage as shown by the deaths alone; and it would be justice to infer that many cases occur that recover, and that the exact number of cases originating within the state bears a like proportion to the whole as the number of deaths bear to the total deaths. I believe no one will question the justice of this deduction; and granting such to be true we would be astounded at the number originating within Colorado could we procure accurate statistics. The fact that tuberculosis is yearly increasing within the state among people who have had no opportunity, or at least very slight opportunities, of contracting it elsewhere and imparting it, is reason sufficient that some action should be taken by the health authorities to protect the public. This is not the only reason, but if there were no other, in my opinion, at least, it would justify immediate action.

From whence comes this original tuberculosis? Surely our climate and telluric conditions do not predispose. Indeed not! It arises from one, and only one, source,—the consumptive who comes here seeking his health. Is it just, let me ask, for the unfortunate consumptive—for unfortun-

ate he is—to come among us bringing with him his affliction and to subject our healthy members of society to infection? If he had smallpox it would not be tolerated. And again, is it just that we greet him when looking for a place to house himself, with a large placard: "No Consumptives Taken"? Indeed not! The injustice is equal on both sides. The public has rights that the consumptive must recognize, and the consumptive has rights that the public must recognize. They are not incompatible, although they may appear so.

The right of the public—and I believe the time has come when it will demand it—is protection against infection. The law of self preservation is a fundamental one, and the right of the public is based thereon. Each and every one of us resent attacks of any kind directed against our existence. We attack crime with our laws, penal institutions and reformatories, and contagious diseases with our health authorities armed with good statutes and a plentiful knowledge of quarantine and isolation details; and yet how little is done for the consumptive and the public in tuberculosis. I speak of both the consumptive and the public because I maintain that both will be benefitted by the adoption of proper procedures.

A protection against infection does not exist. Several attempts have been made, such as signs prohibiting promiscuous expectoration, etc., but which have not affected the death rate in tuberculosis, nor lessened to any appreciable extent its spread. The physician, 'tis true, appreciates the danger and frequently warns his patient of it and advises him of his duty to the public; but alas how often do we see our patients utterly ignoring our advice and subjecting others unnecessarily to their infection. The only way for the right of the public to be achieved without encroaching upon the liberty of the consumptive is for the consumptive to adopt such measures, based upon the truths that bacteriology and hygiene have given us, as will lessen as much as possible his continuing to be a source of infection.

What rights have the consumptives?

(a) The right to gain his health by any known means, be they climatic, hygienic, dietetic or therapeutic in character.

(b) The right of personal liberty and freedom of action in the same degree as is ordinarily enjoyed by individuals, but only so far as such liberty and action does not subject others to the danger of contracting tuberculosis from him. As soon as he assumes freedom of action that will imperil the health of the public, he steps beyond the confines of his rights and encroaches upon those of the public. And the reverse is also true, that as soon as the public deny the consumptive the right to regain his health or use his freedom of action, it encroaches upon the domain of the consumptive.

Tuberculophobia—for so I designate the unnecessary dread and fear of tuberculosis which has lately affected the public—is indeed an injustice to the consumptive. Everywhere he goes he meets it; and it is becoming harder and harder every year for him to obtain suitable surroundings excepting, of course, in the various sanitariums devoted to tuberculosis, the average of which is usually beyond the finances of the average consumptive.

Viewing the matter from the standpoint of the consumptive it is indeed serious. If he be afflicted with a hectic flush and seizures of coughing he is told, when applying for a lodging, that consumptives are not taken and is barred admittance. If he is sick and requires hospital attention, he has but a very limited number of institutions to choose from. If he is successful in breaking down these barriers, he does so because his appearance indicates good health or because he is able to induce others to believe that his affliction is only bronchitis, asthma or some other affection

—any will do as long as it is not tuberculosis. This is, indeed, a sad state of affairs,—the strong, healthy public trampling upon the weak and debilitated consumptive. It is as much the duty of the health authorities to correct this condition as it is for them to protect the public health. I believe that with an earnest endeavor on our part, aided by time and education, that a reconciliation in the nature of a compromise can be effected between these two opposing forces, and that the consumptive will, by the general adoption of measures which will eliminate as much as possible his continuing to be a source of infection, find in the public a most sympathetic and welcome aid. And I believe that the public, when it sees the consumptive striving to regain his health and at the same time protecting others from infection, will lay aside this dread and show its respect by aiding his struggle, through the erection of free sanitariums, clinics and individual assistance.

Shall we or shall we not report our cases of tuberculosis? This question has given rise to much thought by many physicians. For my part I think we should, for without such report the health authorities can not take any action towards educating the consumptive or protecting the public; and thus far the attempts of individual physicians have not met with the good results expected. In order to know who is tubercular and who is not, the stage of the disease that exists and the address of the patients, the authorities must receive reports stating these facts from the physicians. Colorado, enjoying the reputation it has as a health resort especially adapted to the treatment of tuberculosis, also enjoys unexcelled advantages for the study of tuberculosis in all of its intricate phases. Our reputation extends throughout the world, and so will our work. If any community should adopt any measures tending to establish a better understanding between the consumptive and the public, that community should by all means be Colorado. As our climate and physicians are looked upon, by the medical profession at least, as the best obtainable in treating tuberculosis, so also any measures adopted by our health authorities and approved by our medical societies will be looked up to and esteemed as bearing the endorsement and embodying the mature thought and consideration of our physicians.

Looking over our population we find a large proportion of it tubercular; and though based upon observation alone, I will say that the ratio of tubercular individuals to the healthy is as great if not greater than in any other large community. If such is the case then the opportunities of infection are correspondingly great; though I dare say that the proportion would be decreased could we have accurate statistics of the number of cases originating within the state. In other words, even though the opportunities of infection are as great, the infection itself is not so great, our climate, sunshine, etc., in a measure protecting us.

I can not refrain from illustrating with the account of a case that came under my observation recently. A chambermaid, born in Colorado, and stating that she had had no opportunities of contracting tuberculosis elsewhere, came to my clinic for treatment of bronchitis. She stated that previous to her present occupation she always enjoyed excellent health. On examination I found an incipient phthisis. The inference to me is quite plain, for I do not doubt but that her tuberculosis is directly due to her frequent exposure to the bacilli which had been disseminated through the atmosphere and inhaled while sweeping the rooms occupied by one or more careless consumptives. Furthermore, I believe that our hotels, boarding and lodging houses, form a most prominent source of infection owing to their lack of proper hygiene. Many more cases

of tuberculosis derive their infection from this source than ever occur from inhalation of the much dreaded germ-laden air of the streets. We will accomplish more by putting our prohibitive expectoration signs in the rooms of hotels, boarding houses and even private families, than by attempting to establish a "Spotless Town" by placing them on the telephone poles.

What can we expect, what will be the results of reporting all cases of tuberculosis? In the first place it will provide health authorities with the absolutely necessary information. No reform, no educational procedures can be accomplished until we know whom it is necessary to educate or reform. We already know that the public needs it, and we must know who the tubercular individual is so that he also may receive it. In the second place it provides us with the most valuable statistical information and places at our disposal knowledge that can be used for the benefit of mankind. And in the third place it will not in any manner, if properly understood and appreciated, influence the chances of a consumptive in regaining his health nor render more difficult his opportunities; on the contrary it will assist him, being as it is the foundation of any attempt to better existing conditions.

As to the best method of accomplishing a compromise and reconciliation between the present opposing forces, the consumptive and the public, I know of none more promising than the educational. The consumptive must be taught that he is a source of danger to the public, and by adopting protective measures he will lessen this danger. The public must be taught that the consumptive is not dangerous, provided he adopts these measures, and that he is perfectly safe so long as he religiously practices them. Other methods have one common fault, that of restricting beyond reasonable limits the liberty of the consumptive. Compulsory isolation or segregation, though perhaps quite efficient, is absolutely unfeasible and deserves no consideration other than condemnation. Legislation defining the actions and abode of the consumptive and restricting him to certain limits aims at the destruction of personal liberty.

I do not object to any legitimate method of education, whether taught by the health authorities or by a body of ethical medical gentlemen appointed by our civil officers or by the various medical societies, as has been suggested to me, but I believe this work comes properly under the province of the health authorities as it is a matter of public health and they are the only ones, at present, who possess the authority which I believe is necessary to success. I can foresee that should an educational attempt be made by any individuals not possessing authority, how easily a much confused and, in many instances, a wrong impression could be made upon the public mind and the consumptive be misled, and how easily charlatans and quacks could turn to their advantage such a condition. In my opinion the education must be supported by authority, it must be uniform in substance, it must be the truth and be protected from becoming an instrument subverted to private gain.

I would offer the following blank form and regulations for consideration. These have not been adopted by the State Board of Health. They need no comment as they are self explanatory.

FORM.

REPORT OF TUBERCULOSIS.

To the Health Officer of.....

Colorado, ...190.

Sir: I hereby report, as prescribed by law, tuberculosis existing in the person of

..... Address .....

Age..... Race..... Sex

..... Occupation .....

FORM OF DISEASE.

(a) Chronic ulcerative phthisis.
1st stage.
2nd stage.
3d stage.
(b) Fibroid phthisis.
(c) Tuberculosis of upper air passages.
(e) Tuberculosis of skin and appendages.
(f) Acute pneumonic phthisis.
(Galloping consumption.)
(g) Tuberculosis of alimentary tract, genito-urinary tract.
(h) Tuberculosis of nervous system.

(Indicate one or more forms existing by cancelling with pen the form not affecting the person.)

Duration..... Where contracted .....

County ..... State.....

Date .....

How long a resident of Colorado.....

Years.....Month.....

Complications, if any exist,.....

Give names of towns in which patients have resided since coming to Colorado...

.....Health Officer.

.....M. D.

Jurisdiction.....

In accordance with the powers conferred by law upon the State Board of Health, and for the purpose of preventing unnecessary sickness and death, tuberculosis is hereby declared to be a disease dangerous to the public health; and it is hereby ordered that every case of said disease occurring in the State of Colorado be reported by the attending physician or householder to the local board of health, as provided by statute; and it is further ordered that the local board of health, or its executive officer, report the same to the State Board of Health without unnecessary delay, on blanks to be furnished by the State Board of Health.

REGULATIONS GOVERNING TUBERCULOSIS.

(a) Every case of tuberculosis occurring in the State of Colorado, whether originating within or without the state, shall be reported to the local Board of Health by the attending physician or householder. The local Board of Health shall report the same to the State Board of Health without unnecessary delay.

(b) After the death of every case of tuberculosis, the premises occupied by the deceased during life shall be thoroughly fumigated by any of the methods approved by the State Board of Health.

(c) Every person suffering from tuberculosis reported to any local board of health shall be warned by such local board of the danger he is to others, and shall be instructed by such local board in the best measures to adopt to lessen as far as possible the danger to the public. Such measures to be approved by the State Board of Health.

(d) In all cases of chronic ulcerative phthisis, third stage, acute miliary phthisis, acute pneumonic phthisis, and phthisis of the upper air passages, when a change of residence is made by the patient, and notification of such change is made to the local board of health, the place of residence formerly occupied by the patient shall be thoroughly fumigated by using any of the methods of fumigation approved by the State Board of Health.

(e) These regulations give no person any authority to institute quarantine or interfere in any manner with the liberties of any person suffering from tuberculosis within the State of Colorado.

The regulations, however, I will explain.

Section A provides for the report of all cases of tuberculosis by either the physician or householder to the local board of health, and the forwarding of such report to the State Board of Health by the local board, or its health officer.

Section B provides for the fumigation

after the death of any individual from tuberculosis in any of its manifestations.

Section C provides the educational feature and compels local boards of health to warn the consumptive of the danger he is to the public and to teach him how to care for himself in the manner least liable to transfer his infection. This instruction is to be approved by the State Board of Health and, except for possible small local restrictions, will be uniform in character, a point in my opinion of very great importance.

Section D provides for the fumigation of rooms, residences, etc., occupied by consumptives having tuberculosis in the forms most likely to spread the disease. It provides for fumigation only when a consumptive changes his residence; and it will be compulsory for the consumptive suffering from any of the named forms of tuberculosis to notify the local health authorities. This will form a part of the instruction to be sent to every consumptive. It would be an impossibility to keep track of the frequent changes of lodging of the average consumptive; and no other feasible plan presented itself.

You will say: "It will be hard to enforce it." True enough; but if the educational method is the proper course to pursue, the consumptive, as he becomes educated, will report of his own accord; or if not, then upon sufficient evidence a fine could be levied based upon refusal to obey a regulation of the State Board of Health, made in accordance with the laws governing public health.

Section E is self explanatory, and aims directly at those who with authority or acting upon apparent but not possessed authority, would attempt in any manner, by coercion or otherwise, to interfere with the liberty of the consumptive.

The essential points are: The report of cases, which supplies the information and is the foundation of any attempt at restricting the spread of tuberculosis; the provision for fumigation after the death of every case and after a change of residence of those suffering from the chronic ulcerative phthisis (third stage), acute miliary phthisis, acute pneumonic phthisis and phthisis of the upper air passages. We hope this will remove in a large measure the indoor sources of infection. The education of the consumptive is another feature, and finally the protection of the liberties of the consumptive.

In conclusion, I beg to state that I thoroughly appreciate the intricacies and the extent of the subject and that this paper has to do with the protection of both the public and the consumptive, defining the boundaries of the freedom of each. The sociologic phase, the matrimonial and hereditary complications, the disease from the standpoint of the tubercular, the attitude of the public, etc., do not come within the province of this paper, though I must admit that they have been touched upon slightly for illustration. But we wish to know this: Is it the opinion of the medical profession that some action should be taken for the consumptive and the public, and to what extent such action should go?

THE STATE BOARD OF HEALTH AND TUBERCULOSIS.

By J. N. Hall, M. D., Denver.

The State Board of Health proposes a discussion upon the advisability of reporting cases of tuberculosis as the diseases more commonly regarded as contagious are reported. It does this, however, rather to learn the sentiment of physicians throughout the state than to advocate any ideas of its own.

We must at the beginning protest against any too radical measures along the lines proposed. Tuberculous individuals do not forfeit their civil rights by becoming infected. We can ask only that such steps be taken, if any, in the way of official notification as shall enable the com-

munity to protect itself against the danger of a spread of contagion, while at the same time the regulations shall not be offensive nor burdensome to the consumptive.

Probably only those varieties of this multiform disease should at first be notifiable in which distinct danger to others exists. Tuberculous knee and tuberculous meningitis certainly do not come under the same heading in regard to danger as galloping consumption, with a pint of the most infectious sputum daily.

For an initial measure we believe few physicians would dissent from the proposition to require the fumigation of every room recently vacated by a consumptive with active disease. It is done frequently here upon request and could probably be done in every city in this state without creating any ill feeling or opposition. It would be an advantage in two distinct ways. It would in a measure lessen the spread of tuberculosis and keep continually before the people the idea that sanitarians believe the disease to be one calling for the usual precautions used in contagious diseases.

But a great difficulty arises at the outset. Who shall say who is tuberculous and who is not? Scores of consumptives live in hotels, boarding houses and private residences, who are under no medical supervision whatever, and will not see a physician for fear of having their disease definitely named. So long as they can hope that they have nothing more than a chronic bronchitis they can stifle a conscience which tells them they should not teach in the public schools if they really have tuberculosis. I see just such examples frequently. It will be necessary to define very exactly what cases are to be reported, who shall report them, and perhaps even to devise means of getting at the class of persons just spoken of who will not voluntarily go to the doctor. Unless they can be reported by those annoyed by them, as a sanitary nuisance is reported by some neighbor, it is hard to see what can be done to bring them inside the action of the law.

I am sure few if any of those present would advocate any measures toward restricting the liberties of the consumptive. However, if these cases can be reported they can be reached by circulars and other means in such a way that they may be protected against themselves and led to avoid those habits which endanger others.

We may here suggest, though it is not mentioned in our program, that we must be considering even now whether some measures are not called for in pneumonia and influenza as well. The former disease has within a few years far outrun tuberculosis as a cause of death, and bids fair to continue the most dangerous of our foes. Something can be done to lessen the danger of its propagation by destruction of sputum, and by other measures as easily adopted. I believe that we shall see the time when these measures will become compulsory.

I commend to you a careful and frank discussion of all the questions before you that Colorado may act wisely in a matter more serious to her, perhaps, than to any other state in the Union.

Discussion.

Dr. Davis: I was in hopes some of the other people who have paid so much attention to tuberculosis would be here to discuss this most important subject. We are coming to the time when by isolation or by certain rules we can positively curtail the dangers from infection. This is a disease that is destroying more lives in a year than our wars can possibly do. There has been no epidemic which has afflicted humanity in modern times that is responsible for so many deaths as tuberculosis. Consequently, it seems to me it is time to begin to do something to curtail the chances of infection. It almost seems as if radical means should be adopted; but of course, the profession and the laity in general are not ready for radical means. This matter has got to be handled, of course, in as delicate and diplomatic a way as possible, to get the best results. It is to

be hoped the members of the State Society will co-operate with the State Board of Health to in some way advance us along this line. I believe that every case of tuberculosis should be reported. I believe local boards of health should be authorized to compel fumigation of every room that has been occupied by a tubercular patient. I believe, too, that means should be adopted toward preventing expectoration by tubercular patients, not only upon streets, but particularly in rooms. I do not think it requires a very extensive experience to find evidences of infection from dust in apartments occupied by tubercular patients. And I hope that with the aid of the Society and the aid of the profession in general, we can devise some means whereby we may cut down the chances of infection.

Discussion closed by Dr. Cooper: Unfortunately the paper prepared was too long for the time allowed. I hoped to get through with it earlier. But I wish to say this much, that it is my belief that the present attitude of the public is so contrary and so antagonistic to the person having tuberculosis that unless the consumptive adopts measures to protect the public, the consumptive has nothing more to look forward to than absolute isolation. He cannot now get into lodging houses in the city of Denver unless he gets in under false pretenses, as it were. It is a plea for the consumptive. I believe the only way to handle it is through the health boards. Dr. Means of Philadelphia, in a recent article, has shown by original investigatiton that in localities where registration of tuberculosis has been carried out that there is a decrease in tuberculosis of 33.28 per cent over localities similarly situated in which no registration has been performed. I think that in itself is a very good recommendation for it. With that I close my discussion.

ABSTRACTS.

Local Anesthesia.—F. Gregory Connell, Leadville, in his paper upon this subject states: In a large number of minor operations in which ethyl chloride was employed as the local anesthetic, great pain was experienced both during the freezing process and afterwards; the incision or the operation itself caused no pain, and in practically all of the cases the incision was made and the pus evacuated, or the operation completed, before the patient was aware of the fact; but the pain afterwards, during the thawing, was often very severe.

The most common and satisfactory manner of provoking local anesthesia or analgesia is by the subcutaneous injection of a solution of cocaine or some of its succedanea, as Eucaine A, Eucaine B, Tropocaine, Nirvanin, Orthoform, Holocaine, etc.

The chief reason for such a large number of substitutes is the danger of systemic poisoning from the absorption of cocaine. The toxic effect of cocaine varies considerably, but the usual and chief symptoms are such as loss of speech, blindness, nausea, vomiting and syncope. Vertigo is often the first symptom and may sometimes be followed by convulsions. The pulse and respiration are often very irregular and rapid. Out of 250 reported cases of accidental poisoning with cocaine, thirteen terminated fatally. The treatment consists of ammonia, coffee, strychnine, ether, alcohol, morphine and dorsal decubitus if collapse threatens, while, if of the convulsive type, amyl nitrite, bromide, chloral, etc. are indicated.

In a recent series of fifty cocaine injections for analgesia in various pathological conditions, evil effects were noted in three instances. In a series of over eighty cases, in which Eucaine B was employed as the local anesthetic, no such symptoms made themselves manifest.

However, Reclus has done 7,000 operations under local anesthesia, and in all these has never met with a death that could be in any way attributed to it. He places great importance upon the following rules:

Never use a stronger solution than 5 per cent. or 1 per cent.

Always have the patient recline during the administration of the anesthetic, and not get up for half an hour after the operation is completed.

Always have the patient eat or drink something before arising.

Local anesthesia may be divided into the following:

1. Direct anesthesia is obtained by application of the anesthetic substance to a mucous membrane, or its injection subcutaneously into the tissues to be divided.

2. Infiltration anesthesia, the method of Schleich, depends on the thorough infiltration of the tissue, lowering of the temperature of the part, and obtunding the terminal filaments by pressure. The Schleich solution No. 2, the one most generally useful, consists of

Cocaine Muriate, gr. ii (0.1).
Morphine Muriate, gr. ½ (0.025).
Sodium Chloride, gr. iv (0.2).
Distilled Water, oz. iv (120.0).

Constriction of the part, if possible, or the chilling by the low temperature of the injected fluid, or the external application of cold is recommended, because a retardation of the circulation in the infiltrated area will augment the action of the injected drugs, and while prolonging the anesthesia will at the same time diminish the dangers of over-absorption and the occurrence of intoxication; likewise allowing the administration of a much smaller dose than would be necessary if these precautions were not followed out.

With the same result in mind Braun, of Leipsic, earnestly advocates that adrenalin chloride be exhibited before or with the infiltration solution.

3. Regional anesthesia consists of an injection of a comparatively strong, 1 per cent. to 3 per cent., solution of the anesthetic agent into the sensory nerve that supplies the field of operation, usually at a convenient point between the central nervous system and the site of operative interference, although in some cases the nerve or nerves may be injected when they are exposed in the operative wound.

A combination of the infiltration and the regional methods is usually employed, the former for the skin and superficial parts during the dissection and isolation of the nerves; and then the latter by the direct injection into the nerve.

At times it may be inconvenient to expose the nerve by dissection, and then an injection into the perineural tissues will, as a rule, be found ample and sufficient. The injection should be made in the region of the nerve that is to be interfered with, and the nerve surrounded by what Matas termed an anesthetic atmosphere.

The following operations were done under local anesthesia:

The incision and drainage of abscesses in different parts of the body, including ischio-rectal, peri-urethral, and appendiceal.

The removal of ganglion, epithelioma, lipoma, bullets and other foreign bodies, and to enable the proper cleansing of crushed fingers and toes.

Amputation of fingers and toes, and tendorrhapy.

Sequestrotomy of tibia.

Freshening the edges of fractured tibia, for non-union.

Removal of internal saphenous vein, for varicose ulcer.

Plastic operations on nose and face.

Removal of tubercular glands of the neck, and goiter.

Resection of rib for empyema.

Radical cure of inguinal and ventral hernia.

Radical cure of hydrocele, varicocele, and phimosis.

Appendectomy, Talma operation, suprapubic cystotomy, exploratory laparotomy.

Internal urethrotomy, removal of hemorrhoids, and urethral caruncle.

In all of these various operations, in only one instance was there anything like an unsatisfactory result, the others being most satisfactory in their final outcome.

In one of the eight inguinal hernias operated upon by the aid of local anesthesia, there occurred a sloughing of the skin of the margin of the wound.

The advantages to be derived from the

employment of local anesthesia are many, the first and foremost being:

Removal of the danger of death on the table. Others which may be mentioned are:

Avoidance of the after effects of general anesthesia on the heart, kidney, and lung; but post-operative pneumonia seems to occur as frequently after one anesthesia as the other.

No period of post-operative nausea, vomiting or unconsciousness.

No danger of patient being drowned in fecal vomitus.

Patient being conscious, is able to assist the operator in various ways.

Reducing by one the number of assistants; although it will be found to be convenient to have an assistant at the head of the patient to encourage and reassure him, and to be ready to administer a whiff or two of chloroform, if necessary.

There are many cases in which local anesthesia is markedly contraindicated, there is no rational doubt. And on the other hand, that general anesthesia is many times employed unnecessarily is a fact.

We do not urge the promiscuous use of local anesthesia, but we do urge an appreciation of the fact that local anesthesia is safe and practicable, and better than general anesthesia in many cases where the latter is commonly employed. And in attempting to impress this fact we can do no better than to quote from Von Mikulicz, who has said: "The question of today is not which is the safer anesthetic, chloroform or ether, but in what cases can local anesthesia be substituted for anesthesia by inhalation."—*Annals of Surgery*, December, 1903.

COMING MEETINGS.

American Academy of Ophthalmology and Oto-Laryngology.—This organization, which numbers 225 members residing principally in the Middle West, will hold its ninth annual meeting in Denver, August 24, 25 and 26. The scientific sessions will be held at the Brown Palace Hotel at 10 a. m. and 3 p. m., and all physicians are invited to attend them. The program includes symposiums on Tubercular Laryngitis, Non-Suppurative Otitis Media, Cataract Extraction, and Lacrimal Obstruction; and among the papers of general interest will be some on Toxic Amblyopias, Asepsis and Antisepsis during and after Cutting Operations on the Eye-Ball, "How Shall We Educate Our Blind Children," A New Set of Semaphore Signals; and a series of papers on therapeutic subjects, as The Use of Dionin, Adrenalin, etc.

Among those who expect to be present from distant cities are: Drs. E. E. Holt, Portland, Me.; W. L. Pyle and T. B. Schneidemann, of Philadelphia; A. Alt, H. A. Loeb, J. M. Ball and M. A. Goldstein, of St. Louis; Casey A. Wood, J. E. Colburn, G. F. Suker, W. L. Ballenger, E. Pynchon and O. J. Stein, of Chicago; Eugene Smith, of Detroit; H. V. Wurdemann, of Milwaukee; B. E. Fryer, of Kansas City; and Harold Gifford, of Omaha.

Fellowship theses have been submitted by Drs. A. A. Hubbell, of Buffalo; Emil Mayer and J. E. Weeks, of New York; B. A. Randall and G. E. de Schweinitz, of Philadelphia; and C. W. Richardson, of Washington. But how many of these will be read at the meeting is uncertain, since the regular program is well filled by the papers offered by members who will be in attendance.

The Rocky Mountain Inter-State Medical Association. The sixth annual meeting of this Association will be held in Denver at the Brown Palace Hotel, Tuesday and Wednesday, September 6 and 7 prox. All members of the profession, who are interested, are welcome to the scientific sessions. The full program is not yet issued, but the following papers have been promised: Complications and Sequels of Appendicitis, by W. W. Grant, Denver; Hip Joint Disease, S. C. Baldwin, Salt Lake City; Report of Cases of Operations upon the Lung, John C. Monro, Boston; Pregnancy Complicated by Tumors of the Uterus, by D. S. Fairchilds, Des Moines; Peritoneal Tuberculosis, Charles H. Mayo, Rochester; "Hyperchlorhydria," A Common Expression of Neurasthenia and Allied Conditions, J. R. Arneill, Denver; Report of Eight Cases of Pernicious Anemia, J. N. Hall, Denver; Typhoid Fever, A. C. Ewing, Salt Lake City; X-Ray Treatment of Urethral Caruncle, G. H. Stover, Denver; Ectopic Pregnancy, A. A. Kerr, Salt Lake City; Shock, G. C. Stemen, Denver; The

Chemistry of Drug Action, E. C. Hill, Denver.

The officers of the Association are: President, Dr. H. D. Niles, of Salt Lake City; Secretary, Dr. George A. Moleen, of Denver.

The annual banquet will be held on Tuesday evening, tickets $2.00. Railroad rates of one and one-fifth fare for the round trip have been obtained for those desiring to attend the meeting. The list of papers above given is notable for the number of prominent members of the profession from outside of Colorado who have promised to take part in the meeting.

BOOKS.

Progressive Medicine, Vol. II, June, 1904. Edited by Hobart Amory Hare, M. D. Octavo, 334 pages, 47 illustrations. Per annum, in four cloth-bound volumes, $9.00; in paper, $6.00. Lea Brothers & Co., Philadelphia and New York.

The present volume contains a review of the progress in Surgery of the Abdomen, including Hernia, by W. B. Coley; in Gynecology, by J. G. Clark; Diseases of the Blood, Spleen, Thyroid, Lymphatic System and the Diathetic and Metabolic Diseases, by Alfred Stengel; and Ophthalmology, by Edward Jackson.

The articles maintain the high standard previously set in this publication, the peculiar excellence of which lies in the presentation of the new work in each subject as a whole, with a due sense of proportion and appreciation of the relative values of the papers reviewed. It is just this authoritative presentation which is needed by the general reader, and which is wanting in a merely formal series of abstracts. No one wishing to keep intelligently abreast of scientific medical advance can afford not to read carefully these volumes. C. E. E.

International Clinics—Edited by A. J. O. Kelly, Vol. II, 14th Series, 1904. Philadelphia; J. B. Lippincott & Co.

This volume of 322 pages contains articles from 23 well-known writers. Its most striking department is the one on Diseases of Warm Climates. It begins with a paper upon the Spread of Disease by Insects, by Maj. C. F. Mason, U. S. A. This is followed by papers on Recent Progress in Tropical Medicine; The Sleeping Sickness; Hemoglobinuria (two papers); Uncinariasis; Liver Abscess (two papers), and Mode of Life to be Pursued on Return from Sojourn in Tropical Countries.

Under Treatment, are considered Arterio-Sclerosis (two papers); Digitalis and Heart Disease, and Cardiac Valvular Disease with Broken Compensation.

Under Medicine, a Clinical Lecture, dealing with six interesting conditions, is given by Dr. Billings, of Chicago. The other papers deal with Neurotic Asthma, and Osteo Malacia. Surgery is represented by Ankylosed Joints and their Non-Operative Treatment; Abdomino-pelvic Diagnosis; Crushing Injury of the Abdomen; Intestinal Obstruction in Children; and Subparietal Injuries of the Kidney.

Under Pediatrics, Broncho-Pneumonia in Children; and under Rhinology, Nasal Obstruction, are discussed. Two colored plates, 39 plates in black and white, and 19 figures in the text add greatly to the interest and value of these papers, which are more in the nature of monographs than of ordinary journal articles.

DEATHS.

Dr. Earl Hamilton Fish died at his home in Denver, after a brief illness, Tuesday, July 12, aged 31 years. He was born in Providence, R. I., but had spent most of his life in Denver. He graduated at the Denver College of Medicine in 1893. After a year's service as interne at St. Luke's Hospital, Denver, he did post-graduate work at Johns Hopkins Medical School, Baltimore. On his return to Denver he was associated for some years with the late Dr. Parkhill. He then removed to Ouray, where he continued practice, giving special attention to surgery, until a few months before his death. He was a member of the Ouray County Medical Society. In former years he wrote a number of valuable papers, which were published mostly in the Colorado Medical Journal.

Dr. H. S. Torrance, a graduate of the University of Pennsylvania in 1890, was killed by a railroad accident near Cameron on the Cripple Creek Short Line, July 5. He was a member of the Cripple Creek Board of Health, and in former years had been a member of the Colorado State Medical Society.

Dr. Seymour T. Jarecki, a graduate of the College of Physicians and Surgeons, N. Y., class of 1894, was killed at his residence in Denver, June 30, under circumstances leaving doubt as to whether or not the wound was self-inflicted. He was a member of the Colorado State Medical Society, and had served as Assistant County Physician for the City and County of Denver.

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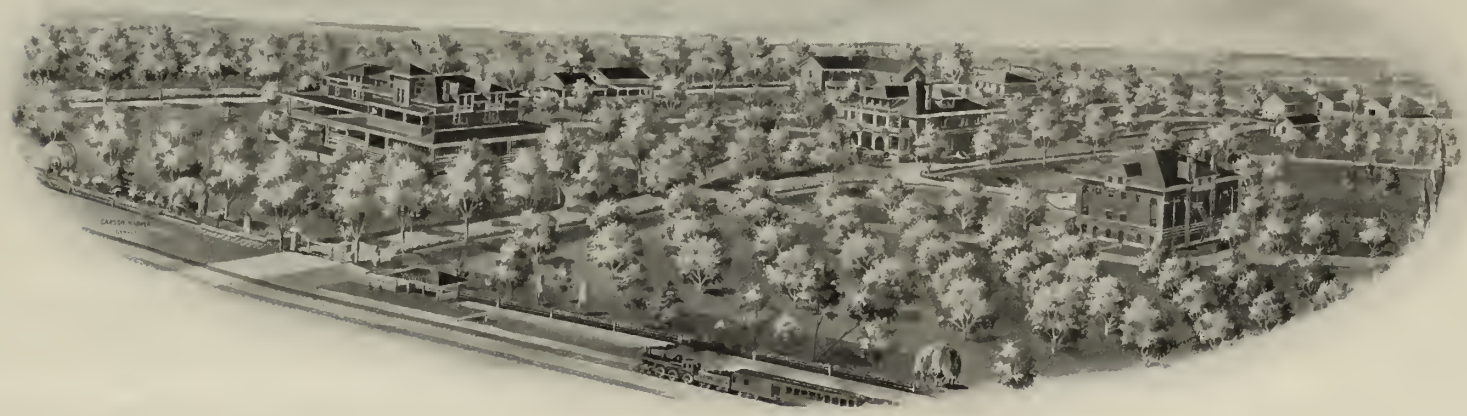

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